SOUTH DAKOTA

CARDIOVASCULAR COLLABORATIVE

RACHEL SEHR, BSN, RN

- **Role:** Heart Disease and Stoke Prevention Coordinator (2017 – Present); Co-chair of Cardiovascular Collaborative
- **Focus Areas:** Quality improvement, team-based care, medication therapy management adoption, implementation of self-measured blood pressure monitoring programs, high blood pressure and cholesterol
- **Background:** Nursing, Disease Intervention Specialist at DOH

OVERVIEW

HOW AND WHY THE COLLABORATIVE WAS FORMED

DID YOU KNOW?

Stroke is the

5th

leading cause of death in the U.S (2016) and

6th

leading cause of death in South Dakota

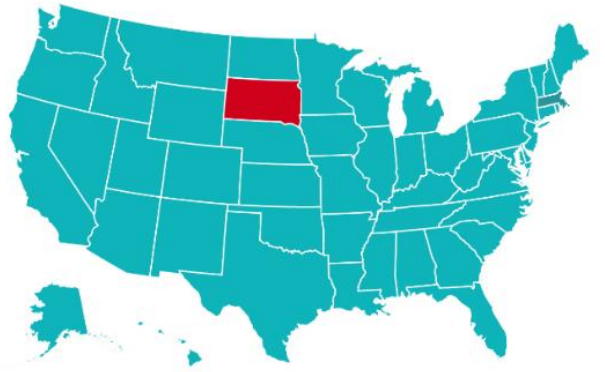
Heart disease is the leading cause of death in the U.S. (2016) and the **2nd leading** cause of death in South Dakota in 2017

31% of South Dakota adults are aware they have high blood pressure; however only

54% have their blood pressure under control

PURPOSE

The Collaborative consists of diverse professionals who collectively want to **improve quality of life** for all South Dakotans through the **prevention and control of heart disease and stroke**.




OUR VISION
Healthy people, healthy communities, healthy South Dakota
OUR MISSION
To improve quality of life of all South Dakotans through prevention and control of heart disease and stroke

South Dakota Cardiovascular Collaborative

State Strategic Plan 2017-2021

Vision: Healthy people, Healthy communities, Healthy South Dakota

Mission: Improve quality of life of all South Dakotans through prevention and control of heart disease and stroke

Download the entire South Dakota Cardiovascular Collaborative Strategic Plan at doh.sd.gov/diseases/chronic/heartdisease

Goals

I. IMPROVE DATACOLLECTION
Drive policy and population outcomes through improved data collection and analysis for heart disease and stroke.

II. PRIORITY POPULATIONS
Address prevention and treatment needs of priority populations in South Dakota for heart disease and stroke.

III. CONTINUUM OF CARE
Coordinate and improve continuum of care for heart disease and stroke.

IV. PREVENTION & MANAGEMENT
Enhance prevention and management of heart disease and stroke.

Objectives

1. Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021.[1] **In Process***
2. Increase input into at least 4 data collection tools by organizations and/or individuals by 10% by 2021.[2] **In Process***

*Integrated across other goal areas

1. Decrease the age-adjusted death rate due to heart disease in the American Indian population from 212.5 per 100,000 to 202.0 per 100,000 by 2021.[3] **Progress: 241.4 per 100,000 (2017)**
2. Decrease the age-adjusted death rate due to stroke in the American Indian population from 48.5 per 100,000 to 46 per 100,000 by 2021.[3] **Progress: 48.2 per 100,000 (2017)**

1. Decrease emergency response times by decreasing average ambulance chute times from 5.23 minutes in 2018 to 4.25 minutes by 2021.[4] **Progress: 5.23 mins (2018)**
2. Increase the number of EMTs in South Dakota from 3,281 EMTs in 2016 to 3,850 EMTs by 2021.[4] **Progress: 3,301 EMTs (2018)**
3. Identify and designate 5 cardiac ready communities by 2021. **Progress: 1 community pursuing designation (2019)**

1. Decrease prevalence of heart attack from 4.7% (2015) to 4.45% (5% decrease) by 2021.[5] **Progress: 4.9% (2017)**
2. Decrease prevalence of stroke from 2.6% (2015) to 2.47% (5% decrease) by 2021.[5] **Progress: 2.7% (2017)**

Strategies

A. Identify and promote tracking of a common set of minimum cardiovascular health data for use for both prevention and improvement of post-cardiac event outcomes.

A. Promote the different models of team-based, patient-centered care (health cooperative clinic, health homes, PCMH).
B. Maximize community-clinical linkages (e.g. CHW, different sectors).
C. Support policies that increase access to heart disease and stroke care for priority populations.
D. Improve collaboration with tribal communities.

A. Utilize results of needs assessment to address infrastructure and sustainability of EMS.
B. Ensure utilization and sustainability of community-based resources and programs such as Mission: Lifeline, LUCAS, and pit-crew CPR for EMS services.
C. Identify and expand mobile integrated health programs.
D. Promote the cardiac ready community program to South Dakota communities ensuring at minimum 5 are enrolled in the program.

A. Encourage the implementation of quality improvement processes in health systems.
B. Promote awareness, detection and management of high blood pressure (clinical innovations, team-based care, and self-monitoring of blood pressure).
C. Support the expansion of prevention and lifestyle interventions in communities and for all ages across the lifespan.

Sources: 1) TBD; 2) Data from healthcare facilities; 3) Vital statistics 2015; 4) ORH EMT database; 5) BRFSS 2015

Last Updated: August 2019

LEADERSHIP TEAM MEMBERS

Name	Organization
Holly Arends	Great Plains QIN/SDFMC
Kevin Atkins	HealthPOINT
Mandi Atkins	South Dakota Health Link
Lori Dumke	CHAD
Mark East	SD State Medical Association
Megan Hlavacek	SD DOH
Kiley Hump	SD DOH
Marty Link	SD DOH
Chrissy Meyer	American Heart Association
Mary Michaels	Sioux Falls Health Department; Chair
Ashley Miller	SD DOH
Gary Myers	American Heart Association
Rachel Sehr	SD DOH
Larissa Skjonsberg	SD DOH

KEY ACHIEVEMENTS

WHAT THE COLLABORATIVE HAS ACCOMPLISHED

TEAM-BASED CARE TOOLKIT & WEBINAR SERIES

What is Team-Based Care?

Health services by at least two health providers collaborating to achieve coordinated, high-quality care

Toolkit & Webinar Series!

Toolkit: an online, how-to resource explaining team-based care, how to get started, and how others in South Dakota have used it

Webinar Series: Online, pre-recorded, step-by-step presentations explaining TBC, what is in the toolkit and how to use it

Who are these resources for?

- Anyone with an interest in team-based care
- Hospital Administrators
- Quality Improvement or Public Health Professionals

View the toolkit & webinar series here: https://doh.sd.gov/diseases/chronic/heartdisease/TeamBasedCareGuide/

COMMUNITY HEALTH WORKER RESOURCE GUIDE

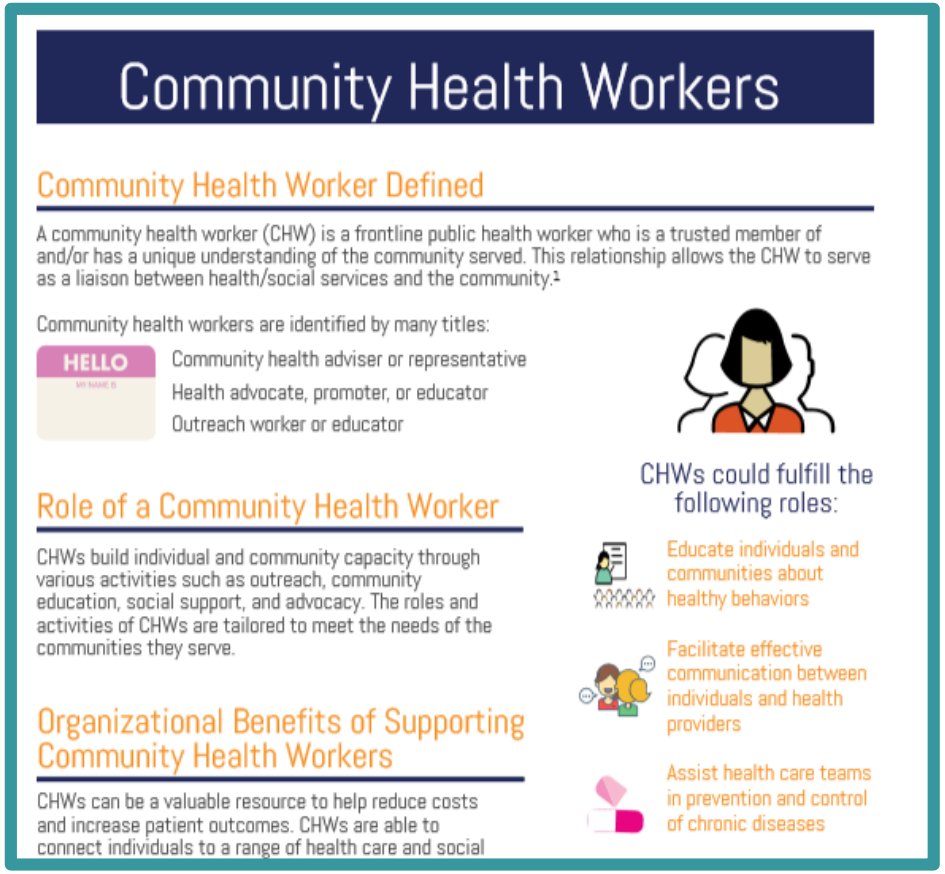
What are Community Health Workers?

Trusted members of the community who serve as liaisons between health/social services and the community

What is in the Resource Guide?

- Overview of the Community health worker model
- Benefits of supporting community health workers in facilities and organizations
- Overview of the Community health worker reimbursement plan

Link to the resource guide: COMING SOON!



Community Health Workers

Community Health Worker Defined

A community health worker (CHW) is a frontline public health worker who is a trusted member of and/or has a unique understanding of the community served. This relationship allows the CHW to serve as a liaison between health/social services and the community.[1]

Community health workers are identified by many titles:

HELLO

Community health adviser or representative

Health advocate, promoter, or educator

Outreach worker or educator

Role of a Community Health Worker

CHWs build individual and community capacity through various activities such as outreach, community education, social support, and advocacy. The roles and activities of CHWs are tailored to meet the needs of the communities they serve.

Organizational Benefits of Supporting Community Health Workers

CHWs can be a valuable resource to help reduce costs and increase patient outcomes. CHWs are able to connect individuals to a range of health care and social

CHWs could fulfill the following roles:

Educate individuals and communities about healthy behaviors

Facilitate effective communication between individuals and health providers

Assist health care teams in prevention and control of chronic diseases

QUALITY IMPROVEMENT RESOURCE GUIDE & WEBINAR SERIES

What is Quality Improvement (QI)?

A systematic approach to achieve measurable improvements to a healthcare system and health status of patients

Resource Guide & Webinar Series!

Resource Guide: an online document explaining what QI is and how to implement it, with a focus on cardiovascular disease

Webinar Series: online, pre-recorded presentations on the following topics: the value case for initiating QI, the QI story, QI in rural areas, and how to use the QI toolkit

Who are these resources for?

- Any organization with an interest in quality improvement
- Hospital Administrators
- Quality Improvement or Public Health Professionals

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Quality Improvement Resource Guide

Welcome

Welcome to the Quality Improvement Resource Guide! This Resource Guide was created through a partnership of the South Dakota Department of Health and the South Dakota Cardiovascular Collaborative. The purpose of this guide is to familiarize you with quality improvement processes as a way of improving clinical quality. While many of the examples within the guide are related to cardiovascular disease, the quality improvement process can be applied to any process or condition where improvements are needed.

Improving Cardiovascular Healthcare

Background

Managing the care of cardiovascular health is as complex as the disease itself. Making clinic-wide, system-level improvements in cardiovascular care can be challenging and time consuming. Quality Improvement (QI) is a process for improving care and the processes for delivering care. It does not specify what improvements should be made, other than that any improvement should be organized, systematic, reproducible, and sustainable.

View the toolkit & webinar series here: https://doh.sd.gov/diseases/chronic/heartdisease/qitoolkit.aspx

CARDIOVASCULAR COLLABORATIVE MEDIA TOOLKIT

What is the Media Toolkit?

A series of downloadable multi-media graphics, text, and videos organizations can share to increase awareness around prevention and management of heart disease, stroke, and diabetes in South Dakota

What topics are in the Toolkit?

- Physical activity
- Reducing Stress
- Healthy Eating
- Blood Pressure
- Heart Health
- Fitness Quiz

View the toolkit and download the graphics here:
https://doh.sd.gov/diseases/chronic/heartdisease/state-plan.aspx

#SDCardioCollab #HeartHealthy

CARDIAC READY COMMUNITIES PROGRAM

What are Cardiac Ready Communities?

Communities with members who are better prepared to help individuals experiencing cardiac events prior to the ambulance arriving to improve chances of survival

What is the Cardiac Ready Communities Program?

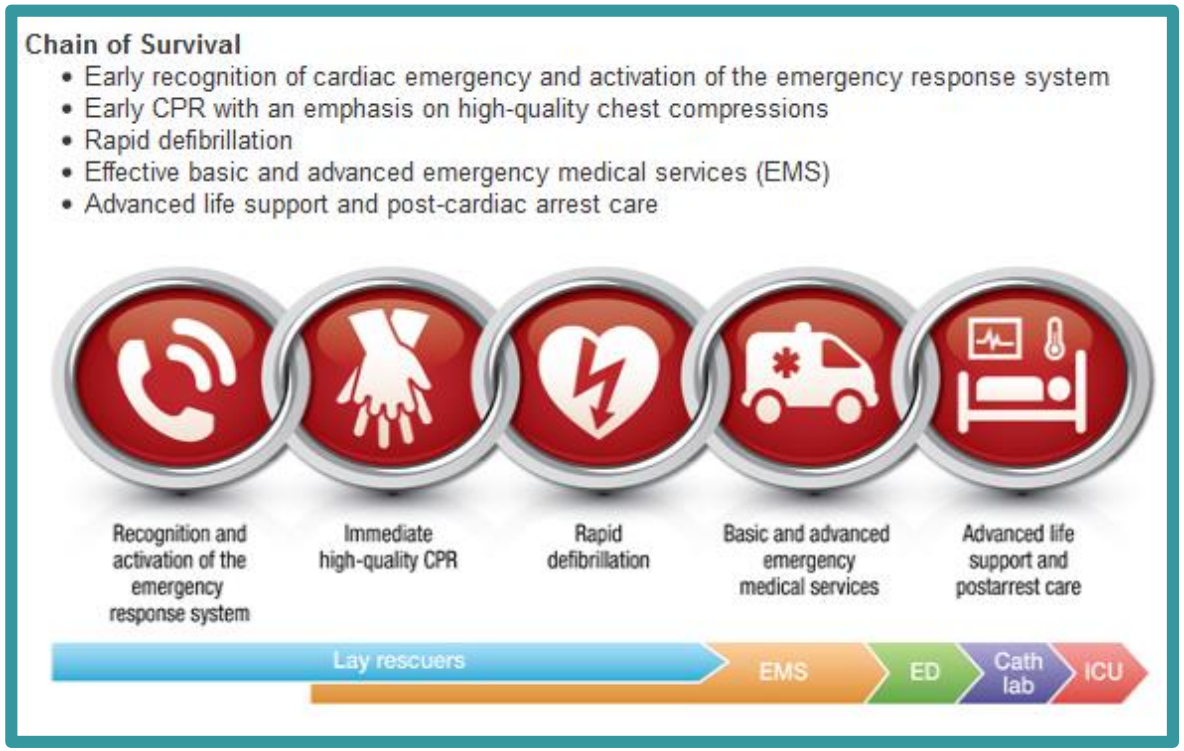
An educational initiative by the SD Department of Health and the Cardiovascular Collaborative that educates, equips, and empowers community members to work collaboratively to assist a person experiencing a cardiac event

Learn more about the program here:
https://doh.sd.gov/cardiacready/

CARDIAC READY COMMUNITIES PROGRAM

A CLOSER LOOK

CARDIAC READY COMMUNITIES PROGRAM



Focus Areas:

1. Community Leadership
2. Community Awareness Campaign
3. Community Blood Pressure Control Program
4. CPR and AED Training
5. Public Access AED Locations
6. EMS Dispatching Program
7. EMS Services
8. Hospital Services
9. CRC Program Evaluation and Sustainability

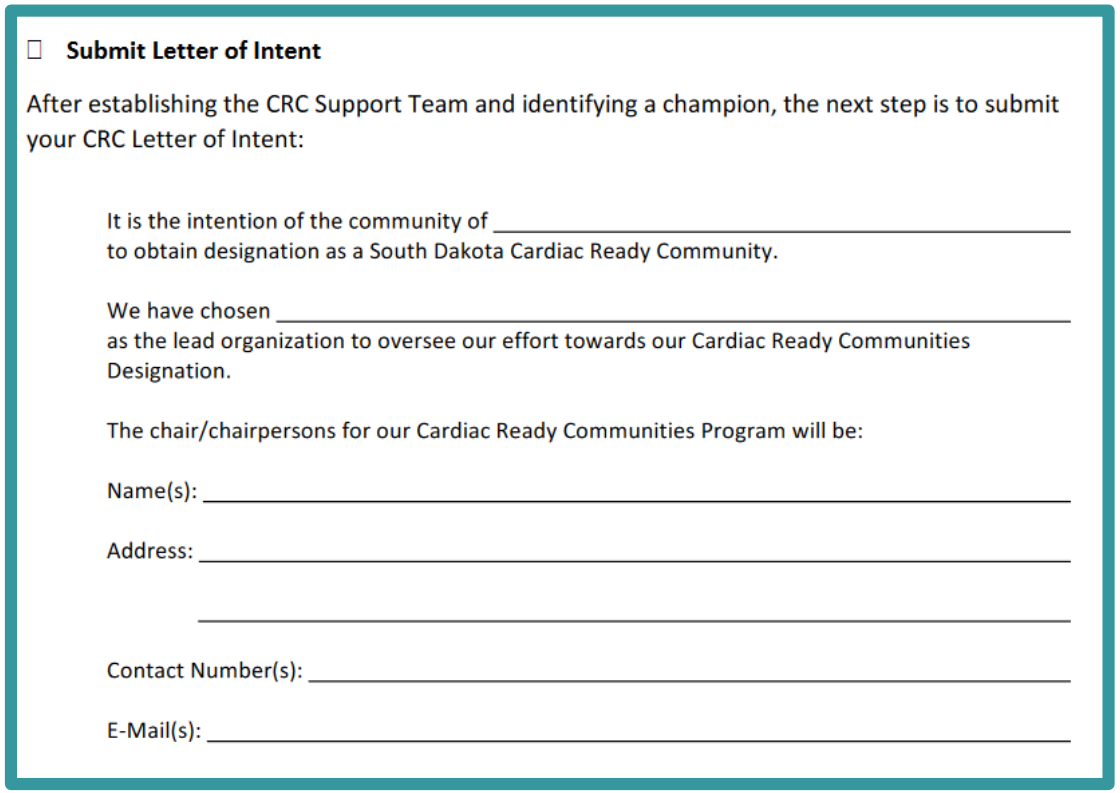
**Based on the American Heart Association Chain of Survival*

BECOMING A CARDIAC READY COMMUNITY (CRC)

- The community will work with the South Dakota Department of Health Heart Disease and Stroke Prevention Program to achieve Cardiac Ready Community Designation
- A minimum score must be achieved in each of the 9 focus areas in order to receive designation

IMPLEMENTATION CHECKLIST

- ✓ Build a Support Team
- ✓ Identify a Champion
- ✓ Submit Letter of Intent
- ✓ Complete an Initial Assessment
- ✓ Select a Focus Area and Create an Action Plan
- ✓ Promote Your Efforts
- ✓ Monitor and Evaluate Progress
- ✓ Select Additional Focus Areas and Repeat
- ✓ Complete and Submit CRC Designation Application
- ✓ Final Meeting with DOH



☐ **Submit Letter of Intent**

After establishing the CRC Support Team and identifying a champion, the next step is to submit your CRC Letter of Intent:

It is the intention of the community of _____
to obtain designation as a South Dakota Cardiac Ready Community.

We have chosen _____
as the lead organization to oversee our effort towards our Cardiac Ready Communities Designation.

The chair/chairpersons for our Cardiac Ready Communities Program will be:

Name(s): _____

Address: _____

_____

Contact Number(s): _____

E-Mail(s): _____

RESOURCES

Program Guide

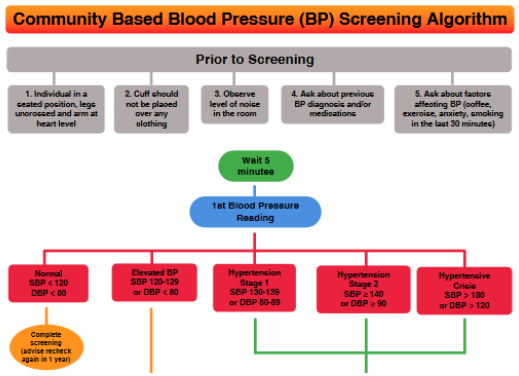
https://doh.sd.gov/documents/diseases/chronic/CRC_ProgramGuide.pdf

Webinar Recording

https://www.youtube.com/watch?v=gTBfJDdCD7Q&feature=youtu.be

Screening Algorithm

https://doh.sd.gov/documents/diseases/chronic/CommunityBasedBloodPressureScreeningAlgorithm.pdf



Weblink

https://doh.sd.gov/diseases/chronic/heartdisease/cardiacreadycommunities.aspx

NEXT STEPS

GETTING INVOLVED WITH THE COLLABORATIVE

5 WAYS TO GET INVOLVED

Tell people in your network or organization about the Collaborative

Read and share the quarterly newsletter, "Heart of the Matter"

Consider becoming a member of the Collaborative

Attend learning events (webinars) sponsored by the Collaborative

Share with us what your organization is doing related to heart disease and stroke

HOW TO JOIN THE COLLABORATIVE & ACCESS THESE RESOURCES

Rachel.Sehr@state.sd.us

(605) 367 - 5356

South Dakota Healthy Life

https://doh.sd.gov/CardioCollaborative/

What can the Collaborative do to help you?

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